guide to
YOUR BENEFITS
AND SERVICES

kaiserpermanente.org

2006 Group Evidence of Coverage Colorado Springs

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INTRODUCTION

About this Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the "Kaiser Permanente Traditional Plan" health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2006 contract year.

ELIGIBILITY AND ENROLLMENT

Who Is Eligible

General
To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

- You must meet your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements), and you must also meet the Subscriber or Dependent eligibility requirements below.
- On the first day of membership, the Subscriber must live in our Service Area (our Service Area is described in the "Definitions" section). You (whether a Subscriber or a Dependent) cannot live in another Kaiser Foundation Health Plan or allied plan service area (for the purposes of this eligibility rule these other service areas may change on January 1 of each year and are currently the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia and Washington). For more information, please call Member Services in ***Denver/Boulder*** at **303-338-3800** or toll-free at **1-800-632-9700** or in ***Colorado Springs*** at **1-888-681-7878**. However, the Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible solely because they live in another Kaiser Foundation Health Plan or allied plan service area if: (1) they are attending an accredited college or accredited vocational school, or (2) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO).

Subscribers
You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements that we have approved (for example, an employee of your Group who works at least the number of hours specified in those requirements).

Dependents
If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

- Your Spouse
- Your or your Spouse's unmarried children (including adopted children) who are under the dependent limiting age (or, if applicable, the dependent student limiting age) specified in the "Summary of Services, Copayments and Coinsurance" section in the Appendix
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - they are under the dependent limiting age specified in the "Summary of Services, Copayments and Coinsurance" section;
  - they receive from you or your Spouse all of their primary support and maintenance;
  - they reside with you (the Subscriber); and
  - you or your Spouse is the court-appointed guardian (or was before the person reached age 18).
- Your or your Spouse's unmarried children of any age who are medically certified as disabled and dependent upon you or your spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
  - they are dependent on you or your Spouse
  - you give us proof of the Dependent's disability and dependency annually if we request it

Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

New Employees and their Dependents
If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible (you should check with your Group to see when new employees become eligible). Your membership will become effective on the date specified by your Group.

Members Who are Inpatient on Effective Date of Coverage
If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other group coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

Special Enrollment Due to Newly Acquired Dependents
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

- For newborn children, the moment of birth. A newborn child is automatically covered for the first 31 days, but must be enrolled within 31 days after birth for membership to continue.
- For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
- For all other Dependents, the date of the event if enrolled within 31 days of attaining eligibility. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Kaiser Permanente, unless (a) they enroll under special circumstances, as agreed to by your Group and Health Plan or (b) they enroll under the provisions described in "Special Enrollment Due to Loss of Other Coverage" below.

Special Enrollment Due to Loss of Other Coverage
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after the enrolling persons lose other coverage, if:

- The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason) and
- The loss of the other coverage is due to (i) exhaustion of COBRA coverage, or (ii) in the case of non-COBRA coverage, loss of eligibility or termination of employer contributions, but not cause or individual nonpayment

Exception: if you are enrolling yourself as a Subscriber along with at least one eligible Dependent, it is necessary for only one of you to lose other coverage and only one of you to have had other coverage when you previously declined Health Plan coverage.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date your Group receives the enrollment application.

Open Enrollment
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

Kaiser Permanente Senior Advantage Limitation on Enrollment
Denver/Boulder Members. If the Kaiser Permanente Senior Advantage plan has reached its capacity limit that the Centers for Medicare & Medicaid Services ("CMS") has approved, you may be ineligible to enroll.

Persons Barred From Enrolling

- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.
- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for failure to pay any amounts (other than Dues) owed to Health Plan or a Plan Provider as described under "Termination for Nonpayment of Any Other Charges" in the "Termination of Membership" section.

HOW TO OBTAIN SERVICES

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described under the following headings:

- Out-of-Plan Emergency Services, in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section
- Out-of-Plan Non-Emergency, Non-Routine Care in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section
- Getting a Referral, in this section

Your Primary Care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your health care needs, including hospital stays and referrals to specialists. Every member of your family should have his or her own primary care Plan Physician.

You may select a primary care Plan Physician from family medicine, pediatrics, or internal medicine. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the section below entitled "Second Opinions."

Denver/Boulder Service Area
You may choose your primary care Plan Physician from our provider directory. If you want to receive care from a specific physician listed in the directory, call Member Services to verify that the physician still participates with the Plan and is accepting new patients. You may obtain a copy of the directory by calling Member Services at **303-338-3800** or you may obtain a list of Plan Physicians on our website, **kaiserpermanente.org**, by clicking on "Locate our services" then "Medical staff directory."

Colorado Springs Service Area
You must choose a primary care Plan Physician when you enroll. If you do not select a primary care Plan Physician upon enrollment, we will assign you one near your home.

The Medical Group contracts with a panel of affiliated care physicians, specialists, and other health care professionals to provide medical Services in the *Colorado Springs Service Area*. You may choose your primary care Plan Physician from our panel of affiliated primary care Plan Physicians. You can identify these physicians, along with a listing of affiliated specialists and ancillary providers, in the Affiliated Practitioner Directory. You may obtain a copy of the directory by calling Member Services at **1-888-681-7878** or you may obtain a list of Affiliated Physicians on our website, **kaiserpermanente.org**, by clicking on "Locate our services" then "Medical staff directory."

If you are seeking **routine or specialty care** in any of the *Denver/Boulder* Plan Facilities, you must have a referral from your local primary care Plan Physician. If you do not get a referral, you will be billed for the full amount of the office visit Charges. If you are visiting in the *Denver/Boulder* metropolitan area and need after hours or emergency care, you can visit a *Denver/Boulder* Plan Facility without a referral.

Changing Your Primary Care Plan Physician

Denver/Boulder Service Area
Call Member Services at **303-338-3800** or toll free at **1-800-632-9700** to change your primary care Plan Physician, or you may change your physician when visiting a Plan Facility. You may change your primary care Plan Physician at any time.

Colorado Springs Service Area
Call Member Services at **1-888-681-7878** to change your primary care Plan Physician. Notify us of your new primary care Plan Physician choice by the 15th day of the month. Your selection will be effective for the first day of the following month.

Getting a Referral

Denver/Boulder Service Area

Medical Group Physicians offer primary medical and pediatric care as well as specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Medical Group Physician decides that you require covered Services not available from us, he or she will refer you to a non-Medical Group physician inside or outside our Service Area. You must have a written referral to the non-Medical Group physician in order for us to cover the Services. A referral is a written authorization from the Plan for you to receive a covered Service from a non-Medical Group physician. A written or verbal recommendation by a Medical Group Physician or an Affiliated Physician that you obtain non-covered Services (whether medically necessary or not) is

NOT considered a referral, and is NOT covered. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Medical Group Physician.

In order to receive Services from providers other than a Medical Group Physician or from a Plan Facility, you must have a referral. This includes Services provided by an Affiliated Physician in the *Denver/Boulder* or *Colorado Springs Service Areas*.

A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance according to Medical Group procedures. We will not pay for any care rendered or recommended by a non-Medical Group physician beyond the limits of the original referral unless the care is specifically authorized by your Medical Group Physician and approved in advance in accord with Medical Group procedures.

Colorado Springs Service Area

Plan Physicians offer primary medical and pediatric care as well as specialty care in areas such as general surgery, orthopedic surgery and dermatology. If your Plan Physician decides that you require covered Services not available from us, he or she will refer you to a non-Plan provider inside or outside our Service Area. You must have a written referral to the non-Plan provider in order for us to cover the Services. A referral is a written authorization from the Plan for you to receive a covered Service from a designated non-Plan provider. A written or verbal recommendation by a Plan Physician that you obtain non-covered Services (whether medically necessary or not) is **NOT** considered a referral and is NOT covered. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Plan Provider.

A Plan authorization is required for Services provided by: 1) non-Plan providers or facilities and 2) Services provided by any provider outside the *Colorado Springs Service Area*. This includes Services provided by a Medical Group Physician in the *Denver/Boulder Service Area*. Plan authorization may be required for Services performed in any facility other than the physician's office. A referral for these Services will be submitted to the Plan by the Plan Physician. The Plan will make determination regarding authorization for coverage.

The provider to whom you are referred will receive a notice of Plan authorization by fax. You will receive a written notice of Plan authorization in the mail. This notice will tell you the physician's name, address and phone number. It will also tell you the time period for which the referral is valid and the Services authorized.

Specialty Self-Referrals

Denver/Boulder Service Area

You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department. You will still be required to obtain a written referral for laboratory or radiology Services and for specialty procedures such as a CAT scan, MRI, colonoscopy or surgery. A written referral is also required for specialty-care visits to non-Medical Group physicians.

Colorado Springs Service Area

You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals. You will find the specialty-care providers eligible to receive direct referrals in the Provider Directory which is available on our website, **kaiserpermanents.org**, by clicking on "Locate our services" then "Medical staff directory." You may obtain a paper copy of the directory by calling our Member Services Department at **1-888-681-7878**.

A self-referral provides coverage for routine visits only. Authorization from the Plan is required for: 1) Services in addition to those provided as part of the visit, such as surgery; 2) visits to Plan Physician specialty-care providers not eligible to receive direct referrals; and 3) non-Plan physicians. Medical Group Physicians in the *Denver/Boulder Service Area* will not be eligible for self-referrals. Services other than routine office visits with a Plan Physician specialty-care provider eligible to receive self-referrals will not be covered unless authorized by the Plan before Services are rendered.

The request for these Services can be generated by either your Primary Care Physician or by a specialty-care provider. The physician or facility to whom you are referred will receive a notice of the authorization. You will receive a written notice of authorization in the mail. This notice will tell you the physician's name, address and phone number. It will also tell you the time period that the authorization is valid and the Services authorized.

Second Opinions

Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Physician about any proposed covered Services.

Plan Facilities

Denver/Boulder Service Area
Our contracted hospitals include Exempla Saint Joseph Hospital, Exempla Good Samaritan Medical Center and Children's Hospital.

We offer health care at 18 Plan Medical Offices conveniently located throughout the *Denver/Boulder* metropolitan area. At most of our Plan Facilities, you can usually receive all the covered Services you need, including specialized care. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you.

Plan Medical Offices are listed in our provider directory, which we update periodically. You may obtain a current copy of the directory by calling Member Services at **303-338-3800** or toll-free at **1-800-632-9700**, or you may obtain a list of facilities on our website, **kaiserpermanente.org**, by clicking on "Locate our services" then "Facility directory."

Colorado Springs Service Area
You may access hospital care at Memorial Hospital, our contracted hospital in the *Colorado Springs Service Area*.

When you select your primary care Plan Physician, you will receive your Services at that physician's office. You can identify affiliated physicians and their facilities, along with a listing of affiliated specialists and ancillary providers, in the Affiliated Practitioner Directory. You may obtain a copy of the directory by calling Member Services at **1-888-681-7878** or you may obtain a list of facilities on our website, **kaiserpermanente.org**, by clicking on "Locate our services" then "Facility directory."

Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a life or limb threatening emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan emergency Services, and emergency benefits away from home, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen, are covered at Plan Facilities during regular office hours. Your office visit Charge, as defined in the "Summary of Services, Copayments and Coinsurance" section, will apply. If you need non-emergency, non-routine care after hours, you may use one of the designated after hours Plan Facilities. The Charge for non-emergency, non-routine care received in Plan Facilities after regular office hours, listed in the "Summary of Services, Copayments and Coinsurance" section will apply. For additional information about non-emergency, non-routine care, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section.

Non-emergency, non-routine care received at a non-Plan facility inside our Service Areas is NOT COVERED. If you receive care for minor medical problems at non-Plan facilities inside our Service Areas, you will be responsible for payment for any medical treatment received.

There may be situations when it is necessary for you to receive unauthorized non-emergency, non-routine care outside our Service Areas. Please see "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits" section for coverage information about out-of-Plan non-emergency, non-routine care Services.

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services, Copayments and Coinsurance described in this EOC. The 90-day limit on visiting member care does not apply to a Dependent child who attends an accredited college or accredited vocational school.

Please call Member Services in ***Denver/Boulder*** at **303-338-3800** or toll-free at **1-800-632-9700** or in ***Colorado Springs*** at **1-888-681-7878** to receive more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may obtain visiting member care may change at any time.

You receive the same prescription drug benefit (including Copayments or Coinsurance, exclusions and limitations) as your home service area benefit.

Out-of-Area Student Benefit

A limited benefit is available to Dependents who are full-time students attending an accredited college, vocational or boarding school outside any Kaiser Foundation Health Plan service area. The out-of-area student benefit covers routine, continuing and follow-up care and pays 80% of Charges for covered Services. The student will be responsible for paying the remaining 20% of

Charges. The benefit is limited to $1,200 per calendar year. To qualify for the out-of-area student benefit, the student must be under the Group's Dependent age limit and carry at least 12 credit hours per term. Verification of student status will be necessary. Contact Member Services for more information.

Visiting Member care will continue to apply to students attending an accredited college or vocational school in other Kaiser Foundation Health Plan or allied plan service areas.

Rescheduling of Services

In the event that you fail to make your Copayment or Coinsurance payments, your appointments for non-urgent Services from Plan Providers may be rescheduled until such time as all amounts are paid in full or you have made other payment arrangements with us.

Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to an area not within any Kaiser Foundation Health Plan or allied plan service area, you can continue your membership with this Plan, if you continue to meet all other eligibility requirements. However, you must go to a Plan Facility in a Kaiser Foundation Health Plan or allied plan service area in order to receive covered Services (except out-of-Plan emergency Services and out-of-Plan non-emergency, non-routine care). If you go to another Kaiser Foundation Health Plan or allied plan service area for care, covered Services, Copayments or Coinsurance will be as described under "Visiting Other Health Plan or Allied Plan Service Areas" above.

Using Your Identification Card

Each Member has a Health Plan Identification Card with a Health Record Number on it, which is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. If we ever inadvertently issue you more than one Health Record Number, please let us know by calling Member Services in ***Denver/Boulder*** at **303-338-3800** or toll-free at **1-800-632-9700**. ***Colorado Springs*** Members may call **1-888-681-7878**. If you need to replace your card, please call Member Services in your area.

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide and claims for emergency or non-emergency care Services from non-Plan providers will be denied. If you let someone else use your ID card, we may keep your card and terminate your membership.

BENEFITS

The Services described in this "Benefits" section are covered only if all the following conditions are satisfied:

- A Plan Physician determines that the Services are medically necessary to prevent, diagnose or treat your medical condition. A Service is medically necessary only if a Plan Physician determines that it is medically appropriate for you and its omission would adversely affect your health.
- The Services are provided, prescribed, authorized or directed by a Plan Physician, except where specifically noted to the contrary in the following sections of this EOC:
  - "Out-of-Plan Emergency Care"
  - "Out-of-Plan Non-Emergency, Non-Routine Care"
  - "Emergency Services and Non-Emergency, Non-Routine Care"
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the following sections of this EOC:
  - "Getting a Referral" and "Specialty Self-Referrals"
  - "Out-of-Plan Emergency Care"
  - "Out-of-Plan Non-Emergency, Non-Routine Care"
  - "Emergency Services and Non-Emergency, Non-Routine Care"

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations and Reductions" section.

Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, please refer to the "Summary of Services, Copayments and Coinsurance" section at the end of this booklet.

Outpatient Care

We cover the following outpatient care for preventive care, diagnosis and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility or at home:

- Primary care visits: Services from family medicine, internal medicine, and pediatrics.
- Specialty care visits: Services from providers that are not primary care, as defined above
- Prenatal and postpartum visits
- Consultations with clinical pharmacists (*Denver/Boulder* Members only)
- Outpatient surgery
- Blood, blood products and their administration
- Second opinion
- House calls when care can best be provided in your home as determined by a Plan Physician
- Medical social Services
- Preventive care Services (Please see the "Preventive Care Services" section in this "Benefits" Section for more details)

The following types of outpatient Services are covered only as described under these headings in this "Benefits" section:

- Chemical Dependency Services
- Dialysis Care
- Drugs, Supplies and Supplements
- Durable Medical Equipment (DME) and Prosthetics and Orthotics
- Emergency Services and Non-Emergency, Non-Routine Care
- Family Planning Services
- Health Education Services
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services
- Preventive Care Services
- Reconstructive Surgery
- Skilled Nursing Facility Care
- Transplant Services
- Vision Services
- X-ray, Laboratory and Special Procedures

Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Areas:

- Room and board, such as semiprivate accommodations or, when a Plan Physician determines it is medically necessary, private accommodations or private duty nursing care
- Intensive care and related hospital Services
- Professional Services of physicians and other health care professionals during a hospital stay
- General nursing care

- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge.
- Bariatric surgery is covered when established criteria is met
- Meals and special diets
- Other hospital Services and supplies, such as:
  - Operating, recovery, maternity and other treatment rooms
  - Prescribed drugs and medicines
  - Diagnostic laboratory tests and X-rays
  - Blood, blood products and their administration
  - Dressings, splints, casts and sterile tray Services
  - Anesthetics, including nurse anesthetist Services
  - Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home

Exclusions:

- Dental Services are excluded, except that we cover general anesthesia for dental Services provided to Members who are children with physical, mental or behavior problems.
- Cosmetic surgery related to bariatric surgery.

The following types of inpatient Services are covered only as described under the following headings in this "Benefits" section:

- Chemical Dependency Services
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Reconstructive Surgery
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

Ambulance Services Exclusion:

Transportation by car, taxi, bus, gurney van, minivan and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.

Chemical Dependency Services

Inpatient Medical and Hospital Services

We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

Outpatient Services

Outpatient rehabilitative Services for treatment of alcohol and drug dependency are covered when referred by a Plan Physician. Up to 20 visits per year are covered under your basic medical benefit. Your Group may have purchased additional visits for treatment of alcohol and drug dependency. Please refer to the "Summary of Services, Copayments and Coinsurance" section for further benefit information.

Your Copayment or Coinsurance for group therapy visits will be half of the Copayment or Coinsurance for individual therapy visits, rounded down to the nearest dollar. Each group therapy visit counts as half an individual visit toward your visit limit, if any.

Mental health Services required in connection with treatment for chemical dependency are covered as provided in the "Mental Health Services" section below.

Members who are disruptive or abusive may have their membership terminated for cause.

Chemical Dependency Services Exclusions:

- Residential rehabilitation in a specialized facility unless your Group has purchased additional coverage for this kind of treatment.
- Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

Dialysis Care

If the following criteria are met, we cover dialysis Services related to acute renal failure and end-stage renal disease:

- The Services are provided inside our Service Area;
- You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis;
- The facility is certified by Medicare and contracts with Medical Group; and
- A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover equipment, training and medical supplies required for home dialysis at no Charge.

Drugs, Supplies and Supplements

Drug Formulary

We use a drug formulary. A drug formulary includes the list of prescription drugs that have been approved by our Pharmacy and Therapeutics Committee (P & T Committee) for our Members. Our P & T Committee, which is comprised of Plan Physicians, pharmacists and a nurse practitioner, selects prescription drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The P & T Committee meets monthly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a particular drug is included in our drug formulary, please call Member Services in the ***Denver/Boulder Service Area*** at **303-338-3800** or toll free at **1-800-632-9700**. ***Colorado Springs*** Members may call Member Services at **1-888-681-7878**.

Limited Drug Coverage Under Your Basic Medical Benefit

If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic medical benefit is limited. It includes medications such as post-surgical immunosuppressive drugs required after a transplant. If your Group has **not** purchased supplemental prescription drug coverage, you may obtain these drugs upon payment of $30.00 per prescription, up to a 30-day supply. If your coverage **includes** supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance applies for these types of drugs. (Please refer to the prescription drug benefit description following the “Summary of Services, Copayments and Coinsurance” section for more information.)

Outpatient Prescription Drugs

Unless your Group purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this “Drugs, Supplies, and Supplements” section. If your Group has purchased additional coverage for outpatient prescription drugs, you will find a description of your prescription drug benefit following the “Summary of Services, Copayments and Coinsurance” section. If your prescription drug Copayment or Coinsurance listed in that explanation exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment or Coinsurance. The drug formulary, discussed above, also applies.

Administered Drugs

We cover the following during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:

> Drugs, injectables, radioactive materials used for therapeutic purposes, vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), and allergy test and treatment materials. Internally implanted time-release drugs and injected contraceptives are not covered under this paragraph.

Drugs for Treatment of Prostate Cancer

We cover injectable hormone therapy prescribed for the treatment of prostate cancer. You pay 20% of Charges unless your Group has purchased different coverage for these drugs. If additional supplemental prescription drug coverage has been purchased by your Group, you will find a prescription drug benefit description following the “Summary of Services, Copayments

and Coinsurance" section with more information. If a Plan Physician determines that no clinically equivalent alternative therapy, such as surgery, exists then these drugs are fully covered.

Food Supplements

Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided without Charge during hospitalization. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

Prescribed Supplies and Accessories

Prescribed supplies, when obtained at Health Plan pharmacies or from sources designated by Health Plan, will be provided. Such items include, but are not limited to, home glucose monitoring supplies, disposable syringes, glucose test tablets and tape, acetone test tablets and nitrate screening test strips for pediatric patient home use. Please refer to the prescription drug benefit description following the "Summary of Services, Copayments and Coinsurance" section for more information.

Limitations:

- Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
- Compound medications are covered as long as they are on the compounding formulary. (*Denver/Boulder Service Area*)
- Plan Physicians may request compound medications through the medical exception process. Medical necessity requirements must be met. (*Colorado Springs Service Area*)

Drugs, Supplies and Supplements Exclusions:

- Drugs for which a prescription is not required by law.
- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and Ace-type bandages.
- Drugs or injections for the treatment of sexual dysfunction disorders, unless your Group has purchased additional coverage, which is described in the "Summary of Services, Copayments and Coinsurance" section.
- Any packaging other than the dispensing pharmacy's standard packaging.
- Replacement of spilled, lost, damaged or stolen prescriptions.
- Drugs or injections for the treatment of infertility unless your Group has purchased additional coverage, which is described in the "Summary of Services, Copayments and Coinsurance" section.
- Drugs to shorten the duration of the common cold.
- Drugs to enhance athletic performance.
- Drugs used in the treatment of weight control.
- Drugs which are available over the counter and by prescription for the same strength.
- Unless an exception is approved by Health Plan, drugs not approved by the FDA and not in general use by March 1 of the year immediately preceding the year in which this EOC became effective.

Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover durable medical equipment and prosthetics and orthotics, when prescribed by a Plan Physician, during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the durable medical equipment or prosthetics and orthotics.

Limitation: Coverage is limited to the standard item of durable medical equipment, prosthetic device or orthotic device that adequately meets your medical needs.

Durable Medical Equipment

Durable medical equipment, with the exception of the following, are NOT covered unless your Group has purchased additional coverage for durable medical equipment, including prosthetic and orthotic devices. Please refer to the DME benefit description following the "Summary of Services, Copayments and Coinsurance" section for more information.

Your Plan Physician can provide the Services necessary to determine your need for durable medical equipment and help you make arrangements to obtain such equipment.

- Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.

- Insulin pumps are provided for Type I diabetes when clinical guidelines are met and when obtained from sources designated by Health Plan. Prescribed insulin pump supplies are provided when obtained at Health Plan pharmacies or from sources designated by Health Plan.
- Infant apnea monitors are provided.

Health Plan follows Medicare guidelines to determine which DME items will be provided to Members.

Durable Medical Equipment Exclusions:

- All other durable medical equipment not described above, unless your Group has purchased additional coverage for durable medical equipment. Please refer to the DME benefit description following the "Summary of Services, Copayments and Coinsurance" section for more information.
- Replacement of lost equipment.
- Repair, adjustments or replacements necessitated by misuse.
- More than one piece of durable medical equipment serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.

Prosthetic Devices

We cover the following prosthetic devices, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan:

- Internally implanted devices for functional purposes, such as pacemakers and hip joints. These are covered without Charge.
- Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
- Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate in newborn Members when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
- Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as medically necessary and provided in accord with Medicare guidelines. Such prosthetic devices, including repairs and replacements, are covered upon payment of 20% of Charges.

Your Group may have purchased additional coverage for prosthetic devices. Please refer to the DME benefit description following the "Summary of Services, Copayments and Coinsurance" section for more information.

Prosthetic Devices Exclusions:

- All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. Please refer to the DME benefit description following the "Summary of Services, Copayments and Coinsurance" section. Your Plan Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
- Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

Orthotic Devices

Orthotic devices are NOT covered unless your Group has purchased additional coverage for durable medical equipment, including prosthetic and orthotic devices. Please refer to the DME benefit description following the "Summary of Services, Copayments and Coinsurance" section for more information.

Emergency Services and Non-Emergency, Non-Routine Care

"Emergency Services" means health care Services provided in connection with an event that you reasonably believe threatens your life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. Emergency Services are available from Plan Hospitals at all times - 24 HOURS A DAY, 7 DAYS A WEEK.

As described below, you are covered for medical emergencies anywhere in the world. For information about emergency benefits away from home**, *Denver/Boulder*** Members may call Member Services at **303-338-3800** or toll-free at **1-800-632-9700**. ***Colorado Springs*** Members may call **1-888-681-7878**.

In case of a life or limb threatening emergency, call 911 or go immediately to the nearest emergency room.

Emergency Services Provided By Plan Providers

Denver/Boulder Service Area

If you are not sure whether your situation is an emergency, call **303-338-4545** for advice, 24 hours a day, 7 days a week. Deaf, hard of hearing or speech impaired Members who use TTY may call **303-338-4428**. If an ambulance is necessary, we will authorize it.

When you call, we may tell you to go directly to the emergency room of a Plan Hospital or to our nearest facility. If an ambulance is medically necessary, we will authorize it. If your condition warrants immediate medical attention to prevent death or serious impairment of health**,** you should seek care immediately by calling **911** or go to one of the Plan Hospitals listed below.

Emergency Department at Exempla Saint Joseph Hospital
off 20th Avenue between Lafayette Street and Franklin Street
Denver, CO 80218

Emergency Department at Exempla Good Samaritan Medical Center
200 Exempla Circle (at Highway 42 and Highway 287)
Lafayette, CO 80026

Children's Hospital
1056 East 19th Avenue (at Downing Street)
Denver, CO 80218

In addition, we have contracted for emergency Services at the following Plan Hospitals:

Swedish Medical Center
501 East Hampden Avenue
Englewood, CO 80110

Lutheran Medical Center
8300 West 38th Avenue
Wheat Ridge, CO 80033

Sky Ridge Medical Center
10101 RidgeGate Parkway
Lone Tree, CO 80124

For other "after hours" medical needs, call **303-338-4545** or deaf, hard of hearing or speech-impaired Members who use TTY may call **303-338-4428.**

Emergency Services that Plan Physicians provide, arrange or authorize in advance, including ambulance Service, are covered. In the event of an emergency, you may **call 911.**

Colorado Springs Service Area

If you are not sure whether your situation is an emergency, you may call your Plan Physician for direction. Your Plan Physician or an on-call designee is available 24 hours per day, 7 days a week.

If it is determined that your situation warrants immediate medical attention to prevent death or serious impairment of health, you may seek care immediately by calling **911** or going to the facility listed below:

Memorial Hospital
1400 East Boulder Street
Colorado Springs, CO 80909
719-365-5000

Emergency Services that Plan Physicians provide, arrange or authorize in advance, including ambulance Service, are covered. In the event of an emergency, you may **call 911.**

Out-of-Plan Emergency Services

"Out-of-Plan Emergency Services" are emergency Services that are not provided or authorized in advance by a Plan Physician. There may be times when you or a family member may receive emergency Services from non-Plan providers. The patient's medical condition may be so critical that you cannot call or come to one of our Medical Offices or the emergency room of a Plan Hospital, or hospital where we have contracted for emergency Services, or, the patient may need emergency Services while traveling outside our Service Area.

Limitation:

If you are admitted to a non-Plan hospital outside the Service Area, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible by calling the **Patient Transfer Coordinator** toll-free at **1-800-632-9700** or, in the ***Colorado Springs Service Area*** at **1-888-681-7878.** We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our facilities would have been possible.

We cover out-of-Plan emergency Services as follows:

- **Outside our Service Area.** If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for emergency Services, or a Plan Facility. Covered benefits include medically necessary out-of-Plan emergency Services for conditions that arise unexpectedly, such as myocardial infarction, appendicitis or premature delivery.
- **Inside our Service Area.** If you are inside our Service Area, we will cover out-of-Plan emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

Emergency Services Exclusions:

- Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery performed by Plan Physicians, full-term delivery and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.
- Continuing or follow-up treatment. We cover only the out-of-Plan emergency care that is required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area. When approved by Health Plan or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other transportation medically required to move you to a designated facility for continuing or follow-up treatment.

Non-Emergency, Non-Routine Care Provided by Plan Providers

Denver/Boulder Service Area

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities during regular office hours. If you need non-emergency, non-routine care **during** office hours and you are a Member in the *Denver/Boulder Service Area*, you may visit one of our Plan Facilities.

Non-emergency, non-routine care needed **after hours**, that cannot wait for a routine visit, can be received at one of our designated after hours Plan Facilities. For information regarding the designated after hours Plan Facilities, please call Member Services at **303-338-3800** or toll free at **1-800-632-9700**.

You may also call **303-338-4545** during regular office hours and one of our advice nurses can speak with you. After office hours, you may call **303-338-4545** for a recorded message about your options and/or to speak with the answering service who will redirect your call, 24 hours a day, 7 days a week.

Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

Colorado Springs Service Area

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan facilities during regular office hours. If you are a *Colorado Springs* Member and need non-emergency, non-routine care **during** regular office hours, you may call your Plan Physician's office.

For non-emergency, non-routine care needed **after hours** that cannot wait for a routine visit, call your Plan Physician's office or you may use one of the clinics listed below.

- Memorial Hospital Briargate Medical Campus Urgent and After Hours Care, 8890 North Union Boulevard, **719-365-2888**.
- Memorial Hospital Urgent and After Hours Care, 2502 East Pikes Peak Avenue, **719-365-2888**; 11:00 a.m. – 11:00 p.m., 7 days a week .

- For Members whose primary care Plan Physician is affiliated with Colorado Springs Health Partners (CSHP), you may also use: CSHP After Hours Clinic, 209 South Nevada Avenue, **719-636-2999**.
- For Members who reside in Pueblo or Canon City, you may also use: Park West Urgent Care located at 3676 Parker Boulevard, Pueblo West.

Check with your primary care Plan Physician for specific information on the after hours phone numbers you should call. Be sure and write down these numbers so that you can have ready access to them when you need them.

Out-of-Plan Non-Emergency, Non-Routine Care

There may be situations when it is necessary for you to receive unauthorized non-emergency, non-routine care outside our Service Area. Non-emergency, non-routine care received from non-Plan providers is covered only when obtained outside our Service Area, if all of the following requirements are met:

- The care is required to prevent serious deterioration of your health;
- The need for care results from an unforeseen illness or injury when you are temporarily away from our Service Area; and
- The care cannot be delayed until you return to our Service Area.

Payment

Health Plan's payment for covered out-of-Plan emergency services and out-of-Plan non-emergency, non-routine care Services is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:

- does not exceed most Charges which providers in the same area charge for that Service;
- does not exceed the usual Charge made by the provider for that Service; and
- is in accord with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

Our payment is reduced by:

- the Copayment or Coinsurance amount for emergency Services, which does not apply if you are admitted directly to the hospital as an inpatient;
- the Copayment or Coinsurance amount for ambulance Services, if any;
- Coordination of benefits;
- any other payments you would have had to make if you received the same Services from our Plan Providers;
- all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
- amounts you or your legal representative recover from motor vehicle insurance or because of third party liability.

Note: The procedure for receiving reimbursement for out-of-Plan emergency Services and out-of-Plan non-emergency, non-routine care Services is described in the "Filing Claims and Member Satisfaction Procedure" section below.

Family Planning Services

We cover the following:

- Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control
- Tubal ligations
- Vasectomies
- Voluntary termination of pregnancy

Please see the attached benefit description following the "Summary of Services, Copayments and Coinsurance" section for additional coverage or exclusions, if applicable to your Group.

Note: Diagnostic procedures are covered, but not under this section (see "X-ray, Laboratory and Special Procedures"). Contraceptive drugs and devices are not covered under this section (see the "Drugs, Supplies and Supplements" section and the prescription drug benefit description following the "Summary of Services, Copayments and Coinsurance" section if your Group has purchased supplemental prescription drug coverage).

Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on numerous topics including stress management and nutrition.

When available, health education classes, such as weight control classes or smoking cessation classes are provided upon payment of a reasonable fee.

Colorado Springs Service Area:

Colorado Springs Members may attend health education classes through Memorial Hospital HealthLink, at a discounted rate. Please call **719-444-CARE** for class times, information and fees.

Hearing Services

We cover hearing tests to determine the need for hearing correction. If your Group has purchased additional coverage for hearing aids, you will find an explanation of that benefit following the "Summary of Services, Copayments and Coinsurance" section.

Hearing Services Exclusions:

- Tests to determine an appropriate hearing aid.
- Hearing aids and tests to determine their efficacy, unless your Group has purchased that coverage.

Home Health Care

We cover the following home health care Services only within our Service Area, only if you are confined to your home, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home:

- Skilled nursing care
- Home health aide Services
- Medical social Services

We cover home health care only on a part-time or intermittent care basis, which means:

- Part-time skilled nursing and home health aide Services furnished up to 28 hours per week combined over any number of days per week and furnished less than eight hours per day
- Intermittent skilled nursing and home health aide Services furnished up to 35 hours per week but fewer than eight hours per day for periods of 21 days or less

Note: Physical, occupational and speech therapy are covered, but not under this section (see "Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services"). Also, X-ray, laboratory and special procedures are not covered under this section (see "X-ray, Laboratory and Special Procedures").

Home Health Care Exclusions:

- Custodial care
- Homemaker Services
- Care that Medical Group determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

Special Services Program

If you have been diagnosed with a terminal illness, with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible to receive up to 15 home health visits per lifetime through the Special Services Program. These visits are without Charge until you elect hospice care coverage. Coverage of hospice care is described below.
This Program is designed to allow you and your family time to become more familiar with hospice-type Services and to decide what is best for you. When you have the option to participate in this Program, you can more adequately bridge the gap between your diagnosis and preparing for the end of life.

The difference between this Program and regular visiting nurse visits is that you may or may not be homebound or have skilled nursing care needs, or you may only require spiritual or emotional care. Services available through this Program are provided by professionals with specific training in end-of-life issues.

Hospice Care

We cover home-based hospice care for terminally ill Members inside our Service Area. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you may continue to receive Plan benefits for conditions other than the terminal illness. We cover the following Services and other benefits when prescribed by a Plan Physician and the hospice care team, and received from a licensed hospice approved, in writing, by Kaiser Permanente:

- Physician care
- Nursing care

- Physical, occupational, speech and respiratory therapy
- Medical social Services
- Home health aide and homemaker Services
- Medical supplies, drugs, biologicals and appliances
- Palliative drugs in accord with our drug formulary guidelines
- Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management
- Counseling and bereavement Services
- Services of volunteers

Infertility Services

We cover the following Services:

- Services for diagnosis and treatment of involuntary infertility, including lab, X-ray and artificial insemination.
- Artificial insemination, except for donor semen, donor eggs and Services related to their procurement and storage. X-ray and laboratory procedures in conjunction with conception by artificial means are provided.

Infertility Services Exclusions:

- Services to reverse voluntary, surgically induced infertility.
- All Services and supplies (other than artificial insemination) related to conception by artificial means, prescription drugs related to such Services, and donor semen and donor eggs used for such Services, such as, but not limited to: in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer. These exclusions apply to fertile as well as infertile individuals or couples.

Note: Drugs, supplies and supplements are not covered under this section (see "Drugs, Supplies and Supplements" to find out if any drugs for the treatment of infertility are covered).

Mental Health Services

We cover mental health Services as specified below, including evaluation and Services for conditions which, in the judgment of a Plan Physician, would be responsive to therapeutic management.

Outpatient Therapy

- Up to 20 visits per year for diagnostic evaluation, individual therapy, psychiatric treatment and psychiatrically oriented child and teenage guidance counseling, are provided. Your Group may also have purchased additional coverage expanding the number of visits. Please refer to the "Summary of Services, Copayments and Coinsurance" section for further benefit information.
- Your Copayment or Coinsurance for group therapy visits will be half of the Copayment or Coinsurance for individual therapy visits, rounded down to the nearest dollar. Each group therapy visit counts as half a visit toward your visit limit.
- Visits for the purpose of monitoring drug therapy are covered. Visits for drug monitoring therapy do not count toward your visit limit.
- Psychological testing as part of diagnostic evaluation is covered.

Inpatient Services

We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Coverage is provided for up to 45 days per year. Your Group may have purchased additional coverage increasing the day limits. Please refer to the "Summary of Services, Copayments and Coinsurance" section for further benefit information. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician: room and board, psychiatric nursing care, group therapy, electroconvulsive therapy, occupational therapy, drug therapy and medical supplies while you are a registered bed patient.

Day/Night Care

We cover up to 90 sessions of day care or night care without Charge per year in a Plan Hospital-based program, if you are admitted directly from an inpatient hospital admission into the day/night treatment program. If your inpatient hospital stay does not immediately precede admission into the day/night treatment program, a separate inpatient hospital Copayment or Coinsurance may apply. These 90 sessions are reduced by two sessions for each day of covered hospital care you receive.

Treatment for Biologically-based Mental Health Conditions

Treatment for six specific mental health diagnoses are covered the same as any other illness, injury or disease. These diagnoses are: schizophrenia, schizoaffective disorder, specific obsessive-compulsive disorder, major depressive disorder, bipolar affective disorder and panic disorder.

Mental Health Services Exclusions:

- Evaluations for any purpose other than mental health treatment, such as child custody evaluations, disability evaluations or fitness for duty/return to work evaluations, unless a Plan Physician determines such evaluation to be medically necessary.
- Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, such as attention deficit disorder.
- Mental health Services on court order, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such therapy to be medically necessary.
- Court-ordered testing and testing for ability, aptitude, intelligence or interest.
- Services which are custodial or residential in nature.

Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services

Hospital Inpatient Care and Care in a Skilled Nursing Facility

We cover physical, occupational and speech therapy without Charge while you are an inpatient in a Plan Hospital or a Skilled Nursing Facility, if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period.

Outpatient Care

We cover outpatient physical, occupational and speech therapy for up to the greater of two months or 20 visits per condition per year, for each therapy in a Plan Medical Office or as part of home health care, if in the judgment of a Plan Physician, significant improvement is achievable within a two-month period. Please refer to the "Summary of Services, Copayments and Coinsurance" section at the end of this booklet for additional benefit information.

Multidisciplinary Rehabilitation Services

If, in the judgment of a Plan Physician, significant improvement in function is achievable within a two-month period, we will cover treatment for up to two months per condition per year, in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We cover multidisciplinary rehabilitation Services without Charge while you are an inpatient in a designated facility. Your primary care office visit Copayment or Coinsurance applies each day outpatient treatment is received.

Pulmonary Rehabilitation

Treatment in a pulmonary rehabilitation program is provided upon payment of a $5.00 Copayment per visit if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities. Clinical criteria is used to determine appropriate candidacy for the program, which consists of an initial evaluation, up to six education sessions, up to twelve exercise sessions and a final evaluation to be completed within a two to three-month period.

Limitation: Participation in a pulmonary rehabilitation program is limited to once per lifetime.

Therapies for Congenital Defects and Birth Abnormalities

After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that up to 20 therapy visits per year for each physical, occupational and speech therapy visit are covered for children up to age five for the treatment of congenital defects and birth abnormalities. Such visits shall be distributed as medically appropriate throughout the year without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity.

Limitations:

- Speech therapy is limited to treatment for speech impairments due to injury or illness. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long term and chronic in nature.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions:

- Long-term rehabilitation.
- Speech Therapy that is not medically necessary, such as:
  - Therapy for educational placement or other educational purposes.
  - Training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation.
  - Therapy for tongue thrust in the absence of swallowing problems.

Preventive Care Services

Preventive care Services are Services to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Please refer to the "Summary of Services, Copayments and Coinsurance" section at the end of this booklet for Copayments or Coinsurance that may apply to preventive care Services. Should you receive Services for an existing illness, injury or condition **during** a preventive care examination, you may be charged an additional office visit Copayment or Coinsurance.

Preventive care Services include the following:

- Adult Preventive Care Exam
- Adult Preventive Care Screenings (tests and interpretation)
  - Prostate Specific Antigen (PSA) Screening
  - Fecal Occult Blood (Hemocults) Screening
  - Flexible Sigmoidoscopy Screening (or Screening Colonoscopy when ordered by your Plan Physician)
  - Cholesterol (Lipid Profile) Screening
  - Fasting Blood Glucose Test for Diabetes Screening
- Well-Woman Care
  - Screening pap and interpretation
  - Screening mammogram and interpretation
  - Clinical breast exam
  - Chlamydia screening test and interpretation
- Immunizations
- Well-Child Care (exams and immunizations in accordance with Medical Group guidelines)

Reconstructive Surgery

We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or medically necessary surgery, (b) will correct a congenital defect, disease or anomaly in order to produce significant improvement in physical function, or (c) will treat congenital hemangioma (known as port wine stains) on the face and neck of Members 18 years and younger. Following medically necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

Reconstructive Surgery Exclusions:

Plastic surgery or other cosmetic Services and supplies intended primarily to change your appearance, including cosmetic surgery related to bariatric surgery.

Skilled Nursing Facility Care

We cover up to 100 days per year of skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required. We cover the following Services:

- Room and board
- Nursing care
- Medical social Services
- Medical and biological supplies

- Blood, blood products and their administration

Note: Drugs are covered, but not under this section (see "Drugs, Supplies and Supplements"). Durable medical equipment and prosthetics and orthotics are covered, but not under this section (see "Durable Medical Equipment and Prosthetics and Orthotics"). Physical, occupational and speech therapy are covered, but not under this section (see "Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services"). X-ray, laboratory and special procedures are covered, but not under this section (see "X-ray, Laboratory and Special Procedures").

A Skilled Nursing Facility is an institution that provides skilled nursing or skilled rehabilitation Services, or both, on a daily basis 24 hours a day, is licensed under applicable state law and is approved in writing by Medical Group.

Skilled Nursing Facility Care Exclusion: Custodial care, as defined in the "Exclusions" subsection of the "Exclusions, Limitations and Reductions" section below.

Transplant Services

Transplants are covered on a **LIMITED** basis as follows:

- Covered transplants are limited to kidney transplants, heart transplants, heart-lung transplants, liver transplants, liver transplants for children with biliary atresia and other rare congenital abnormalities, small bowel transplants, small bowel and liver transplants, lung transplants, cornea transplants, simultaneous kidney-pancreas transplants and pancreas alone transplants.
- Bone marrow transplants (autologous stem cell and peripheral stem cell support) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.
- If all medical criteria developed by Medical Group are met, we cover stem cell rescue and transplants of organs, tissue or bone marrow.

Related Prescription Drugs

Prescribed post-surgical immunosuppressive outpatient drugs required as a result of a transplant are provided. Please refer to the prescription drug benefit description that follows the "Summary of Services, Copayments and Coinsurance" section for more information. If your Group has not purchased a supplemental prescription drug benefit, outpatient immunosuppressive drugs will be covered at a Copayment of $30.00 for each prescription, up to a 30-day supply.

Transplant Services Exclusions and Limitations

- Bone marrow transplants associated with high dose chemotherapy for solid tissue tumors, other than bone marrow transplants covered in accord with this EOC, are excluded.
- Non-human and artificial organs and their implantation are excluded.
- Pancreas alone transplants are limited to patients without renal problems who meet established criteria.
- Travel and lodging expenses are excluded, except that in some situations when Medical Group or a Plan Physician refers you to a non-Plan provider outside our Service Area for transplant Services, as described under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. Our travel and lodging guidelines are available from Member Services by calling **303-338-3800** or toll-free at **1-800-632-9700** in the ***Denver/Boulder*** area. ***Colorado Springs*** Members may call **1-888-681-7878**.

Terms and Conditions

- Health Plan, Medical Group and Plan Physicians do not undertake to provide a donor or donor organ or bone marrow or cornea, or to assure the availability of a donor or donor organ or bone marrow or cornea, or the availability or capacity of referral transplant facilities approved by Medical Group. However, in accord with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person identified by Medical Group or a Plan Physician as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our guidelines for Services for living transplant donors are available by calling Member Services in the ***Denver/Boulder*** area at **303-338-3800** or toll-free at **1-800-632-9700.** ***Colorado Springs*** Members may call **1-888-681-7878**.
- Plan Physicians determine that the Member satisfies medical criteria developed by Medical Group for receiving the Services.
- A Plan Physician provides a written referral for care to a transplant facility selected by Medical Group from a list of facilities it has approved. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the

facility selected by Medical Group for the particular transplant, even if another facility within the Service Area could also perform the transplant.

- If, after referral, either a Plan Physician or the medical staff of the referral facility determines that the Member does not satisfy its respective criteria for the Service involved, Kaiser Permanente's obligation is limited to paying for covered Services provided prior to such determination.

Vision Services

We cover refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses. We also cover professional examinations and the fitting of medically necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition.

Professional Services for examinations and fitting of contact lenses that are not medically necessary are provided at an additional Charge when obtained at Health Plan Optical Dispensing Offices.

Your Group may have purchased additional optical coverage. If so, you will find a description of that benefit following the "Summary of Services, Copayments and Coinsurance" section at the end of this booklet.

Vision Services Exclusions:

- Eyeglass lenses and frames
- Contact lenses
- Professional examinations, fittings and dispensing except when medically necessary as described above
- All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy and similar procedures)
- Orthoptic (eye training) therapy

X-ray, Laboratory and Special Procedures

Outpatient

We cover the following Services:

- Diagnostic X-ray and laboratory tests, Services and materials, including isotopes, electrocardiograms, electroencephalograms and mammograms
- Therapeutic X-ray Services and materials
- X-ray and laboratory Services and procedures for the treatment of infertility and conception by artificial means
- Special procedures such as MRI, CT, PET and nuclear medicine

Inpatient

During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET and nuclear medicine are covered without Charge.

X-ray, Laboratory and Special Procedures Exclusion: Testing for family members who are not Members.

EXCLUSIONS, LIMITATIONS AND REDUCTIONS

Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section.

- **Alternative Medical Services.** Acupuncture Services, naturopathy Services, massage therapy, chiropractic Services and Services of chiropractors, unless your Group has purchased additional coverage for these Services. Please refer to the "Summary of Services, Copayments and Coinsurance" section at the end of this booklet for any additional coverage information.

- **Certain Exams and Services.** Physical examinations and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for: employment, participation in employee programs, insurance, disability, licensing, or on court order or for parole or probation.
- **Cosmetic Services.** Services that are intended primarily to change or maintain your appearance and that will not result in significant improvement in physical function, including cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits" section.
- **Custodial Care.** Assistance with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine) or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.
- **Dental Services.** Dental Services and dental X-rays, including dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services resulting from medical treatment such as radiation treatment. This exclusion does not apply to: (i) medically necessary Services for the treatment of cleft lip or cleft palate for newborn Members when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract, or (ii) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Members who are children with physical, mental or behavioral problems and, unless otherwise specified herein, received at a Hospital, Plan facility or Skilled Nursing Facility. The following Services for TMJ may be covered if a Plan Physician determines they are medically appropriate: diagnostic X-rays, laboratory testing, physical therapy and surgery. Office visit Copayments or Coinsurance apply for these covered Services.
- **Directed Blood Donations.** Directed blood donations are not covered**.**
- **Disposable Supplies.** Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits" section.
- **Employer or Government Responsibility.** Financial responsibility for Services that an employer or a government agency is required by law to provide.
- **Experimental or Investigational Services:**

  a) A Service is experimental or investigational for a Member's condition if any of the following statements apply to it as of the time the Service is or will be provided to the Member. The Service:

  1) cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted; or
  2) is the subject of a current new drug or new device application on file with the FDA; or
  3) is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the Service; or
  4) is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; or
  5) is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity or efficacy of Services; or
  6) is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being evaluated for its safety, toxicity or efficacy; or
  7) is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (i) use of the Service should be substantially confined to research settings or (ii) further research is necessary to determine the safety, toxicity or efficacy of the Service.

  b) In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

  1) The Member's medical records;
  2) The written protocol(s) or other document(s) pursuant to which the Service has been or will be provided;
  3) Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service;
  4) The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
  5) The published authoritative medical or scientific literature regarding the Service as applied to the Member's illness or injury; and

6) Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

c) If two or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d) Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

- **Genetic Testing.** Genetic testing unless determined to be medically necessary and meets criteria established by Medical Group.
- **Intermediate Care.** Care in an intermediate care facility.
- **Routine Foot Care Services.** Routine foot care Services that are not medically necessary.
- **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan emergency Services or out-of-Plan non-emergency, non-routine care.
- **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
- **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded, except for Services we would otherwise cover to treat complications of the non-covered Service.
- **Sexual Reassignment.** All Services related to sexual reassignment.
- **Surrogate.** Services related to conception, pregnancy or delivery in connection with a surrogate arrangement. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.
- **Travel and Lodging Expenses.** Travel and lodging expenses are excluded, except that in some situations when Medical Group or a Plan Physician refers you to a non-Plan provider outside our Service Area for transplant Services as described under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Travel and lodging expenses are not covered for Members who are referred to a Center of Excellence for non-transplant medical care. Our travel and lodging guidelines are available from Member Services by calling **303-338-3800** or toll-free at **1-800-632-9700** in the ***Denver/Boulder*** area. ***Colorado Springs*** Members may call **1-888-681-7878**.
- **Weight Management Facilities.** Services received in a weight management facility.
- **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
  - Any source providing a Financial Benefit or from whom a Financial Benefit is due.
  - You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law.

Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. However, in these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

Reductions

Coordination of Benefits (COB)

The Services covered under this EOC are subject to coordination of benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB rules of the National Association of Insurance Commissioners. Those rules are incorporated into this EOC. If both we and the other coverage cover the same Service, we and the other coverage will see that up to 100% of your covered medical expenses are paid for that Service. The COB rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this EOC is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during the year to pay for your out-of-pocket expenses for Services that are partially covered by either us or your other coverage. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about COB, please call our Patient Business Services Department at:

Denver/Boulder Service Area: **303-743-5900**

Colorado Springs Service Area: **719-867-2165**

You may also write us at: Kaiser Foundation Health Plan of Colorado, Patient Business Services, 2500 South Havana Street, Aurora, CO 80014-1622.

Injuries or Illnesses Alleged to be Caused by Other Parties

You must reimburse us 100% of Charges for covered Services you receive for an injury or illness that is alleged to be caused by another party, except that you do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as permitted by law, including but not limited to, any recovery you receive from: a) uninsured motorist coverage; b) underinsured motorist coverage; c) automobile medical payment coverage; d) workers' compensation coverage or e) any other liability coverage.

If you are involved in an automobile-related accident, please contact us immediately so that we can coordinate benefits with the automobile insurance carrier and determine whether we or the automobile insurance carrier have primary coverage. Please contact our Patient Business Services Department at the phone numbers provided above.

To the extent permitted by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

To secure our rights, we shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any other party, regardless of whether the other party admits liability. The proceeds of any judgment or settlement that you, your attorney or your representative obtain shall first be applied to fully satisfy our lien, regardless of whether the total amount of your recovery from all sources is less than the actual or estimated losses and damages you incurred, and regardless of how the proceeds are characterized or itemized. We specifically deny any application of the Made Whole doctrine.

We will not be responsible for any fees incurred by you in obtaining any such judgment or settlement. Any costs we incur will be borne by us and any costs of your representation will be borne by you. We specifically deny any application of the Common Fund doctrine. Any proceeds of such judgment or settlement in the possession of you or your attorney shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against any other party, you must send written notice of the claim or legal action to **Patient Business Services, 2500 S. Havana Street, Suite 500, Aurora, CO 80014-1622**. In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, any other party and any respective insurer to pay us or our legal representatives directly. You must cooperate in protecting our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian or conservator and any settlement or judgment recovered by the estate, parent, guardian or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Health Plan to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

FILING CLAIMS AND MEMBER SATISFACTION PROCEDURE

Filing Claims

Health Plan will review claims that you make for Services or payment, and we may use medical experts to help us review claims and appeals. There are four types of claims, each of which has a different procedure described below:

- Post-Service claims
- Non-urgent pre-Service claims
- Urgent pre-Service claims
- Concurrent care claims when your course of treatment will expire

If you disagree with any pre-Service denial we make based on a determination that a requested Service is not medically necessary, or effective, or is experimental or investigational, your physician has the right to request a reconsideration of our decision by contacting the physician or department who initially made the denial. Your physician acting on your behalf has the right to request a reconsideration of the denial. This request for reconsideration may be made verbally or in writing to the department that initially made the denial. The reconsideration shall occur within five (5) calendar days of receipt of the request, and it shall be conducted between the provider who is rendering, or will render the Service and the reviewer who made the initial denial, or that reviewer's designated clinical peer in the event that the reviewer cannot be available within five (5) days.

The procedures you must follow for internal appeals are described below. It is not necessary for your physician to request reconsideration before you request an appeal.

If you miss a deadline for filing a claim or appeal, we may decline to review it. If your health benefits are provided through the Employee Retirement Income Security Act (ERISA), you can file a demand for arbitration or civil action under ERISA Section 502(a)(1)(B), but you must meet any deadlines and exhaust the claims and required appeals procedures before you can do so. If you are not sure if your Group is an "ERISA" group, you should contact your employer. We do not charge you for claims or appeals, but you must bear the cost of anyone you hire to represent or help you.

Post-Service Claims and Appeals

Post-Service claims are requests for payment for Services you already received, including claims for out-of-Plan emergency Services. If you have any questions about post-Service claims or appeals, in the ***Denver/Boulder Service Area***, please call either our Claims Department at **303-338-3600** or Member Services at **303-338-3800** or **303-338-3820** (TTY), Monday-Friday, 8:00-5:00 p.m. In the ***Colorado Springs Service Area***, please call **1-888-681-7878** or deaf, hard of hearing or speech-impaired Members who use TTY may call **1-800-521-4874**.

Procedure for making a post-Service claim

1. Claims for out-of-Plan emergency, out-of-Plan non-emergency, non-routine care or other health care Services received from non-Plan providers must be filed on forms provided by Health Plan and may be obtained by calling or writing to:

   Denver/Boulder Service Area*:*

   Claims Department
   Kaiser Foundation Health Plan of Colorado
   P.O. Box 373150
   Denver, CO 80237-3150
   303-338-3600 or **303-338-3354** (TTY)

   or

   You may call Member Services at **303-338-3800** or **303-338-3820** (TTY)

***Colorado Springs Service Area**:*

Kaiser Foundation Health Plan of Colorado
c/o Meridian Health Care Management
P. O. Box 1561
Bellevue, NE 68005-1561

or

You may call Member Services at **1-888-681-7878** or **1-800-521-4874** (TTY)

You must send the completed claim form to us within 180 days after you receive out-of-Plan Services or Services from non-Plan providers. Attach itemized bills along with receipts if you have paid the bills. Return the completed claims to the address listed on the claim form. Incomplete claim forms will be returned to you. This will delay any allowed payments. Also, you must complete and submit to us any documents that we may reasonably request for processing your claim or obtaining payment from insurance companies.

2. We will review your claim, and if we have all the information we need, we will send you a written decision within 30 calendar days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we tell you we need more time and ask you for more information, you will have 45 calendar days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will make a decision based on the information we have. We will issue our decision within 15 calendar days of our receipt of the additional information, or if no information is received, within 15 calendar days of the deadline for receiving the information.
3. If we deny your claim (if we do not pay for all the Services you requested), our written decision will tell you why we denied your claim and how you can appeal.

Procedure for appealing our denial of a post-Service claim

1. Within 180 days after you receive our written decision denying your claim, you, or a representative you designate in writing, may write to our Appeals Department telling them that you want to appeal our denial of your claim for Health Plan to pay for a Service you already received. Explain all of the reasons why you disagree with our denial of your claim and include all supporting documents. Your written request and the supporting documents constitute your appeal. In the *Denver/Boulder Service Area*, you may send your appeal request to: Appeals Department, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066, Denver, CO 80237-8066. In the *Colorado Springs Service Area*, send your appeal request to: Member Appeals, Kaiser Foundation Health Plan of Colorado, 1975 Research Parkway, Suite 250, Colorado Springs, CO 80920.
2. We will review your appeal and send you a written decision within 30 calendar days after we receive your appeal.
3. If we deny your appeal, our written decision will tell you why we denied your appeal and notify you of whether you have the right, under certain circumstances, to file a voluntary second level appeal or an external review.
4. If you are not satisfied with the result of the first level of appeal, under certain circumstances, you have the right to request a voluntary second level appeal or an external review. In those circumstances, you may submit your request for a voluntary second level appeal in writing to our Appeals Department at the address shown above within 30 days of receiving the decision of the first level appeal. A review hearing will be held within 60 calendar days of receipt of the request for a second level appeal. You have the right to present your appeal in person or to be represented by a person of your choice. A written decision will be issued within seven (7) calendar days of the hearing, citing the reasons upon which the decision was based. If your appeal is totally or partially denied, we will also notify you of your right, under certain circumstances, to request an external review.

Pre-Service Claims and Appeals

Pre-Service claims are requests that Health Plan provide or pay for a Service that you have not yet received. If you have any questions about pre-Service claims please contact Member Services in the ***Denver/Boulder Service Area*** at **303-338-3800,** or in the ***Colorado Springs Service Area*** at **1-888-681-7878.** If you have questions about appeals, please contact our Appeals Department at **303-344-7933**.

Procedure for making a non-urgent pre-Service claim

1. Contact Member Services and tell them that you want to make a claim for Health Plan to provide or pay for a Service you have not yet received. Your written or verbal request and any related documents you give us constitute your claim. In the ***Denver/Boulder*** *Service Area*, you may call or write to: Member Services, 2500 South Havana Street, Aurora, CO 80014-

1622, 303-338-3800. In the ***Colorado Springs Service Area***, you may call or write to: Member Services, Kaiser Foundation Health Plan of Colorado, 1975 Research Parkway, Suite 250, Colorado Springs, CO 80920, 1-888-681-7878.

2. We will review your claim, and if we have all the information we need we will make our decision within fifteen (15) calendar days after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within fifteen (15) calendar days of receipt of your claim. We encourage you to send all the requested information at one time so that we will be able to consider it all when we make our decision. Upon receipt of the requested information, we will make and issue a decision within fifteen (15) calendar days. If we do not receive any of the requested information (including documents) within forty-five (45) days, we will then make a decision within fifteen (15) calendar days of the information due date based on the information we have.

3. If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our written decision will tell you why we denied your claim and how you can appeal or request reconsideration.

Procedure for appealing our denial of a non-urgent pre-Service claim

1. Within 180 days after you receive our written decision denying your claim, you, or a representative you designate in writing, may appeal our denial of your claim for Health Plan to provide or pay for a Service you have not yet received. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your written request and the supporting documents constitute your appeal. In the *Denver/Boulder Service Area*, you may send your appeal request to: Appeals Analyst, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066, Denver, CO 80237-8066. In the *Colorado Springs Service Area*, send your appeal request to: Member Appeals, Kaiser Foundation Health Plan of Colorado, 1975 Research Parkway, Suite 250, Colorado Springs, CO 80920.

2. We will review your appeal and send you a written decision within thirty (30) calendar days after receipt of your appeal request.

3. If we deny your appeal, our written decision will tell you why we denied your appeal, and will notify you of whether you have a right to file a voluntary second level appeal. We will also notify you of whether you have a right, under certain circumstances, to request an external review.

4. If you are not satisfied with the result of the first level of appeal, under certain circumstances you have the right to request a voluntary second level appeal. In those circumstances, you may submit your written request for a voluntary second level appeal to our Appeals Department, at the address shown above, within 30 days of receiving the first level appeal decision. A review hearing will be held within 60 calendar days of receipt of the request for a second level appeal. You have the right to present your appeal in person or to be represented by a person of your choice. A written decision will be issued within seven (7) calendar days of the hearing, citing the reasons upon which the decision was based. If your appeal is totally or partially denied, we will also notify you of your right, under certain circumstances, to request an external review.

Procedure for making an urgent pre-Service claim

1. Contact Member Services and tell them that you want to make an urgent claim for Health Plan to provide or pay for a Service you have not yet received. Your written or verbal request and any related documents you give us constitute your claim. In the ***Denver/Boulder Service Area***, you may call or write to: Member Services, 2500 South Havana Street, Aurora, CO 80014-1622, **303-338-3800**. In the ***Colorado Springs Service Area***, you may call or write to: Member Services, Kaiser Foundation Health Plan of Colorado, 1975 Research Parkway, Suite 250, Colorado Springs, CO 80920, **1-888-681-7878**.

2. If your urgent request is not submitted according to these procedures, you will be notified in writing within 24 hours of the proper procedures for filing your request.

3. If we determine that your claim is not urgent, we may treat your claim as non-urgent.

4. We will review your claim and if we have all the information we need, we will notify you and your physician of our decision verbally within 72 hours after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within 24 hours of receipt of your claim. You will have 48 hours from the time of notification to provide the missing information. We will make a decision: (a) within 48 hours after receipt of the requested information or (b) at the end of the 48-hour period given you to provide the specified additional information, whichever comes first.

5. Written confirmation of the determination will be provided within three (3) days following our verbal notification. Our written decision will tell you why we denied your claim and how you can appeal or request reconsideration.

Procedure for appealing our denial of an urgent pre-Service claim

1. You, or a representative you designate in writing, may call or write an Appeals Analyst and tell them that you want to appeal our denial of your urgent claim for Health Plan to provide or pay for a Service you have not yet received. Explain all of the

reasons why you disagree with our denial of your claim and include all supporting documents. Your written or verbal request and the supporting documents constitute your urgent appeal. Send your urgent appeal request to: Appeals Analyst, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066, Denver, CO 80237-8066, or call our Appeals Department at **303-344-7933** or toll-free **at 1-888-370-9858**, or fax your request to **303-344-7951**.

2. You may request an expedited appeal of the denial of your urgent pre-Service claim. Your request for an expedited appeal will be accepted only if the denied Service (a) could seriously jeopardize your life, health or ability to regain maximum function, or if you have a disability, create an imminent and substantial limitation on your existing ability to live independently, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. If you receive any of the Services you are requesting before we make our decision, your appeal will become a non-urgent appeal with respect to those Services. (See Procedure for appealing our denial of a non-urgent pre-Service claim.)

3. We will review your appeal and notify you of our decision verbally or in writing within 72 hours after we receive your appeal. If we notify you verbally, we will send you a written decision within three (3) calendar days after that.

4. If we deny your appeal, our written decision will tell you why we denied your appeal and will include any further review options that may be available to you. We will also notify you of your right, under certain circumstances, to request an external review.

Concurrent Care Claims

Concurrent care claims are requests that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment prescribed will expire. If you have any questions about concurrent care claims please contact Member Services in the ***Denver/Boulder Service Area*** at **303-338-3800**, or in the ***Colorado Springs Service Area***, please call **1-888-681-7878**. If you have questions regarding appeals, please call our Appeals Department at **303-344-7933**.

Procedure for making a non-urgent concurrent care claim when your course of treatment will expire

1. At least 24 hours before the expiration of the course of treatment, contact a representative of the department that initially notified you that you want to make a concurrent care claim for Health Plan to continue to approve a course of treatment that is expiring. Your written or verbal request and any related documents you give us constitute your claim.

2. We will review your claim and notify you of our decision verbally or in writing within 24 hours after we receive your claim. Written confirmation of the determination will be provided within three (3) days following verbal notification.

3. If we deny your claim (if we do not agree to continue approval of all the Services you requested), our written decision we will tell you why we denied your claim and how you can appeal.

Procedure for appealing our denial of concurrent care claims

1. You, or a representative you designate in writing, may call or write an Appeals Analyst and tell them that you want to appeal our denial of your request that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment prescribed will expire, provide or pay for a Service you have not yet received. Explain all of your reasons why you disagree with our denial of your claim, and include all supporting documents. Your written or verbal request and the supporting documents constitute your appeal. Send your appeal request to: Appeals Analyst, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066, Denver, CO 80237-8066, or call our Appeals Department at **303-344-7933**, or fax your request to **303-344-7951**.

2. We will review your appeal and notify you of our decision verbally or in writing within 72 hours after we receive your appeal. If we notify you verbally, we will send you a written decision within three (3) calendar days after that.

3. If we deny your appeal, our written decision will tell you why we denied your appeal, and will include any further review options that may be available to you. We will also notify you of your right, under certain circumstances, to request an external review.

External Review

The Colorado Division of Insurance contracts with independent external review organizations to provide independent review of decisions made by Health Plan regarding health care Services when certain circumstances exist. You may request an external review only: (1) after all required internal appeal processes have been exhausted and (2) upon notice of Health Plan's determination that a health care Service has been reviewed and did not meet Health Plan's requirement for medical necessity, appropriateness, health care setting, level of care, effectiveness, or efficiency, and the requested Service or coverage for the Service was denied, reduced or terminated. Independent external review is voluntary and is provided at no cost to you.

To request an external review you must:

Submit your request for an external review in writing to our Appeals Department, at the address shown above, within sixty (60) calendar days of receiving an adverse determination in denial of your appeal and include the following:

- A completed external review request form as specified by the Division of Insurance. (You will receive this form with your denial notice);
- A signed consent authorizing Health Plan to disclose protected health information pertinent to the external review; and
- Any new information that you feel should be considered.

The independent external review organization will issue its decision within thirty (30) working days of Health Plan's receipt of your request, except that the time period may be extended for up to ten (10) working days for the consideration of additional information.

You may request an "expedited" external review if you have a medical condition where the timeframe for completion of a standard review would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function, or if you have a disability, would create an imminent and substantial limitation of your existing ability to live independently. A request for an expedited review must be accompanied by a written statement from your physician that your condition meets these criteria.

If the independent review organization overturns our denial of payment for care you have already received, we will issue payment within thirty (30) calendar days. If the independent review organization overturns our decision not to authorize care, we will authorize care within five (5) working days.

Member Satisfaction Procedure

If you are not satisfied with the Services received at a particular Medical Office, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by following the procedures listed below.

Denver/Boulder Service Area

- Sending your written complaint to: Kaiser Foundation Health Plan of Colorado, Member Services, 2500 South Havana Street, Aurora, CO, 80014-1622; or
- Requesting to meet with a Member Services Representative at the Health Plan Administrative Offices; or
- Telephoning Member Services at **303-338-3800** or deaf, hard of hearing or speech-impaired Members who use TTY may call **303-338-3820**.

Colorado Springs Service Area

- Sending your written complaint to: Kaiser Foundation Health Plan of Colorado, Member Services, c/o Meridian Health Care Management, 6200 Canoga Avenue, Woodland Hills, CA 91367; or faxing it to Member Services at **1-818-673-6879**; or
- Requesting to meet with a Member Services Representative at Kaiser Permanente Administrative Offices in Colorado Springs, 1975 Research Parkway, Suite 250; or
- Telephoning Member Services at **1-888-681-7878** or deaf, hard of hearing or speech-impaired Members who use TTY may call **1-800-521-4874**.

After you notify us of a complaint, this is what happens:

1. A Member Services Representative reviews the complaint and conducts an investigation, verifying all the relevant facts.
2. The Representative or a Plan Physician evaluates the facts and makes a recommendation for corrective action, if any.
3. When you file a written complaint, we usually respond in writing within 14 calendar days, unless additional information is required.
4. When you make a verbal complaint, a verbal response is usually made within 14 calendar days.

If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to:

Denver/Boulder Service Area

Kaiser Foundation Health Plan of Colorado
Member Services
2500 South Havana Street
Aurora, CO 80014-1622

Colorado Springs Service Area

Kaiser Foundation Health Plan of Colorado
Member Services
c/o Meridian Health Care Management
6200 Canoga Avenue
Woodland Hills, CA 91367

Your written request will be reviewed by Member Services Administration, who will respond to you in writing within 14 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Physicians. Using this Member Satisfaction Procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. ***Denver/Boulder*** Members may call Member Services at **303-338-3800**, or deaf, hard of hearing or speech impaired Members who use TTY may call **303-338-3820**. ***Colorado Springs*** Members may call Member Services at **1-888-681-7878** or deaf, hard of hearing or speech impaired Members who use TTY may call **1-800-521-4874**.

TERMINATION OF MEMBERSHIP

Your Group is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This "Termination of Membership" section describes how your membership may end and explains how you may be able to maintain Health Plan coverage without a break in coverage if your membership under this EOC ends.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Eligibility and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group's benefits administrator to confirm your termination date.

Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Dues, fraud or abuse, while you are an inpatient in a hospital or institution, your coverage will continue until your date of discharge.

Termination for Cause

We may terminate the memberships of the Subscriber and all Dependents in your Family Unit by sending written notice to the Subscriber at least 15 days before the termination date if anyone in your Family Unit commits any of the following acts:

- You are disruptive, unruly, or abusive to the extent that the ability of Health Plan or a Plan Provider to provide Services to you, or to other Members, is seriously impaired;
- You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Physician has made reasonable efforts to promote such a relationship;
- You knowingly: (1) misrepresent membership status, (2) present an invalid prescription or physician order, (3) misuse (or let someone else misuse) a Member ID card, or (4) commit any other type of fraud in connection with your membership; or
- You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will not be allowed to convert to non-group coverage or to re-enroll in Kaiser Permanente. You must pay Charges for any Services received after the termination date. You have the right to appeal such a termination by contacting Member Services at **303-338-3800** for ***Denver/Boulder*** Members, or **1-888-681-7878** for ***Colorado Springs*** Members, or you may contact the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution and pursue appropriate civil remedies.

Termination for Nonpayment

Nonpayment of Dues
You are entitled to coverage only for the period for which we have received the appropriate Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

Nonpayment of Any Other Charges
We may terminate your membership if you fail to pay any amount you owe Health Plan or to a Plan Provider. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. If we receive full payment before the termination date, we will not terminate your membership. Also, if we terminate your membership for nonpayment of any other Charges, we will reinstate your membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date.

Persons whose memberships are terminated for nonpayment of any other Charges may not enroll in Health Plan unless all amounts owed have been paid, and then, only if we approve the enrollment.

Termination for Noncompliance with Medicare Membership Requirements

For Members entitled to Medicare, Medicare is the primary coverage except when federal law (TEFRA) requires that Group's health care plan be primary and Medicare coverage be secondary. Members eligible for Medicare as their secondary coverage are subject to the same Dues and receive the same benefits as Members who are not eligible for Medicare, except that Members who enroll in our Kaiser Permanente Senior Advantage as Secondary Payor plan will have no Copayments or Coinsurance for most covered Services.

If you do not comply with all of the following requirements for any reason, even if you are unable to enroll in a Kaiser Permanente Senior Advantage plan because you do not meet the plan's eligibility requirements, or the plan is not available through your Group or your Service Area, we will terminate your membership upon 30 days' written notice to the Subscriber.

For Members eligible for Medicare as primary coverage, Dues are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered Services provided to Members eligible for benefits under Medicare Part A or B (or both). If you are or become eligible for Medicare as primary coverage, you must comply with the following requirements:

- Enroll in all parts of Medicare for which you are eligible and continue that enrollment while a Member;
- *Denver/Boulder* Members: enroll through your Group in a Kaiser Permanente Senior Advantage plan. *Colorado Springs* Members: assign your Medicare benefits to Health Plan; and
- Complete and submit all documents necessary for Health Plan, or any provider from whom you receive Services covered by Health Plan, to obtain Medicare payments for Medicare-covered Services provided to you.

Continuation of Group Coverage Under Federal Law, State Law or USERRA

Federal Law (COBRA)
You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

State Law
If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Charges to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below or, at your option, convert to non-group membership:

1. Your coverage is through a Subscriber who dies, divorces or legally separates or becomes entitled to Medicare or Medicaid benefits; or
2. You are a Dependent child who ceases to qualify as an eligible Dependent (See “Eligibility and Enrollment” for more details); or
3. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility and Enrollment” section.

To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Charges, no later than 30 days after the date on which your Group coverage would otherwise terminate.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Charges to your Group and terminates on the earlier of:

- 18-months after your coverage would have otherwise terminated because of termination of employment;
- The date you become entitled to Medicare;
- The date you become covered under another group medical plan; or
- The date Kaiser Permanente terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group, but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

Conversion of Membership

You may be eligible to convert to a non-group plan on a direct pay basis if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Eligibility and Enrollment" section, or if you enroll in COBRA or USERRA continuation coverage and then lose eligibility for that COBRA or USERRA coverage. However, you may not convert to this non-group plan if:

- you continue to be eligible for coverage through your Group;
- you live in another Kaiser Foundation Health Plan or allied plan service area, except that the Subscriber's or the Subscriber's spouse's otherwise eligible children are not ineligible to be covered Dependents solely because they live in another Kaiser Foundation Health Plan or allied plan service area if: (1) they are attending an accredited college or accredited vocational school or (2) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO);
- your membership ends because our Agreement with your Group terminates; or
- we terminated your membership under "Termination for Cause" or "Nonpayment of Any Other Charges" in this "Termination of Membership" section.

You must apply to convert your membership within 31 days after your Group coverage ends. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Dues, and the benefits, Copayments and Coinsurance under the non-group coverage may differ from those under this EOC.

For information about converting your membership or about other non-group plans, call Member Services in ***Denver/Boulder*** at **303-338-3800** or toll-free at **1-800-632-9700** or in ***Colorado Springs*** at **1-888-681-7878**.

Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to another Kaiser Foundation Health Plan or allied plan service area, you should contact your Group's benefits administrator to learn about your Group health care options. You may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Dues, Copayments and Coinsurance may not be the same in the other service area.

MISCELLANEOUS PROVISIONS

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Group Agreement and this EOC.

Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make healthcare decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504).

Kaiser Permanente will not discriminate against you whether or not you have an advance directive and will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A healthcare provider or healthcare facility shall provide for the prompt transfer of the principal to another healthcare provider or healthcare facilities if such healthcare provider or healthcare facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507).

Two brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call Member Services in the ***Denver/Boulder Service Area*** at **303-338-3800** or toll-free at **1-800-632-9700**, or in the ***Colorado Springs Service Area*** at **1-888-681-7878**.

Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

Applications and Statements

You must complete any applications, forms or statements that we request in our normal course of business or as specified in this EOC.

Assignment

You may not assign this EOC or any of the rights, interests or obligations hereunder without our prior written consent.

Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

Contracts with Plan Providers

Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call Member Services in ***Denver/Boulder*** at **303-338-3800** or toll-free at **1-800-632-9700**, or in ***Colorado Springs*** at **1-888-681-7878**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

Governing Law

Except as preempted by federal law, this EOC will be governed in accord with Colorado law and any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

Group and Members not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

Named Fiduciary

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this EOC. Also, as a named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members in the ***Denver/Boulder*** **Service Area** who move should call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** as soon as possible to give us their new address. ***Colorado Springs*** Members who are moving should call **1-888-681-7878**.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call 303-338-3800. You can also find the *Notice of Privacy Practices* on our website at kaiserpermanente.org.

DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, mean:

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

Charges: Charges means the following:

- For Services provided by Plan Providers or Medical Group, the Charges in Health Plan's schedule of Medical Group and Health Plan Charges for Services provided to Members;
- For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the Charges in the schedule of Charges that Kaiser Permanente negotiates with the capitated provider;
- For items obtained at a Plan Pharmacy, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan); or
- For all other Services, the payments that Kaiser Permanente makes for the Services (or, if Kaiser Permanente subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Kaiser Permanente would have paid if it did not subtract the Copayment, Coinsurance or Deductible)

CMS: The Centers for Medicare and Medicaid Services, the federal agency responsible for administering Medicare, formerly known as HCFA.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Summary of Services, Copayments and Coinsurance" section.

Copayment: The specific dollar amount you must pay for a covered Service, as listed in the "Summary of Services, Copayments and Coinsurance" section.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility and Enrollment" section).

Dues: Periodic membership Charges paid by Group.

Family Unit: A Subscriber and all of his or her Dependents.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: Health Plan and Medical Group.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Dues. This EOC sometimes refers to a Member as "you" or "your."

Plan Facility: A Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory. Plan Medical Offices are subject to change at any time without notice.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members.

Plan Provider: A Plan Hospital, Plan Physician or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Service Area:

The ***Denver/Boulder Service Area*** is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park and Weld counties within the following zip codes: 80001-7, 80010-22, 80024-28, 80030-31, 80033-34, 80036-38, 80040-42, 80044-47, 80102, 80104, 80107-13, 80116-17, 80120-31, 80134-35, 80137-38, 80150-51, 80154-55, 80160-63, 80201-12, 80214-39, 80241, 80243-44, 80246-52, 80255-56, 80259-66, 80270-71, 80273-75, 80279-81, 80290-95, 80299, 80301-10, 80314, 80321-23, 80328-29, 80401-3, 80421-22, 80425, 80427, 80433, 80437, 80439, 80452-55, 80457, 80465-66, 80470-71, 80474, 80481, 80501-4, 80510, 80513-14, 80516, 80520, 80530, 80533-34, 80537-40, 80542-44, 80601-03, 80614, 80621, 80623, 80640, 80642, 80643, 80651.

The ***Colorado Springs Service Area*** is that portion of Douglas, Elbert, El Paso, Fremont, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132-33, 80808-09, 80813-14, 80816-17, 80819-20, 80827, 80829, 80831-33, 80840-41, 80860, 80863-64, 80866, 80901, 80903-22, 80925-26, 80928-37, 80940-47, 80949-50, 80960, 80962, 80970, 80977, 80995, 80997, 81007-08, 81212, 81240.

Services: Health care Services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your legal husband or wife.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility and Enrollment" section).

APPENDIX

Access Plan

Colorado State law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, call **303-338-3800** in ***Denver/Boulder***, or **1-888-681-7878** in ***Colorado Springs***.

Access to Services for Foreign Language Speakers

- Member Services will provide a telephone interpreter to assist Members who speak limited or no English.
- Plan Physicians have telephone access to interpreters in over 150 foreign languages.

- Plan Physicians can also request an onsite interpreter for an appointment, procedure or Service.
- Any interpreter assistance that we arrange or provide will be at no Charge to the Member.

Binding Arbitration

Except for Small Claims Court cases, claims arising under Section 502(a)(1)(B) of the Employee Retirement Income Security Act (ERISA), claims covered under Colorado Health Care Availability Act, Section 13-64-403, claims reviewed through independent external review as set out in the Colorado Revised Statutes, Section 10-16-113.5, and claims subject to Medicare appeals procedures, any dispute between Members, their heirs, or other associated parties on the one hand and Kaiser Permanente parties on the other hand, for alleged violation of any duty arising from your membership in Health Plan, must be decided through binding arbitration. This includes claims for premises liability, or relating to the coverage for, or delivery of, Services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration. This provision shall not limit an individual's access to procedures for review of utilization management determinations as set out in Colorado Revised Statutes and Division of Insurance Regulation.

Kaiser Permanente Parties include:

a. Kaiser Foundation Health Plan of Colorado (Health Plan);
b. The Colorado Permanente Medical Group;
c. The Permanente Federation, LLC;
d. The Permanente Company, LLC;
e. Kaiser Foundation Hospitals;
f. Any Colorado Permanente Medical Group physician;
g. Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Members or other associated parties; or
h. Any employee or agent of any of the foregoing.

You must use Health Plan procedures to request arbitration. You can obtain a copy of these procedures from our Business and Clinical Risk Management Department at **303-344-7298**. The arbitration hearing will be conducted in accord with Health Plan procedures, the Colorado Uniform Arbitration Act and the Federal Arbitration Act.

Women's Health and Cancer Rights Act

In accord with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance
- Prostheses (artificial replacements)
- Services for physical complications resulting from the mastectomy

SUMMARY OF SERVICES, COPAYMENTS AND COINSURANCE

Benefits for State of Colorado

Group # 225-T08

This section discusses:

- Services and the applicable Copayments or Coinsurance you are responsible for paying
- Annual Out-of-Pocket Maximums
- Dependent limiting age
- Dependent student limiting age

This summary does not fully describe benefits. For a complete understanding of the benefits, exclusions and limitations applicable to your coverage under this plan, it is important to read this EOC in conjunction with this Summary of Services, Copayments and Coinsurance. Please refer to the identical heading in the "Benefits" section and to the “Exclusions, Limitations, and Reductions” section of this EOC.

The Copayments or Coinsurance listed here apply to Services and supplies provided to covered Members enrolled in this plan. Copayments or Coinsurance are due at the time you receive the Service. We reserve the right to reschedule non-urgent care if you do not pay at the time you receive the Service.

If you do not pay your Copayment or Coinsurance at the time of your visit, an administrative fee will be added to the amount you owe us.

Outpatient Care	You Pay
Primary care visits (doctor or nurse visit)	$30 each visit
Specialty care visits (doctor or nurse visit)	$50 each visit
Consultations with clinical pharmacists	$30 each visit
Allergy injections	$30 each visit
Allergy evaluation and testing	$50 each visit
Prenatal and postpartum visits	$15 each visit
Outpatient surgery at designated outpatient facilities	$150 each visit
Preventive care Services	
• Well-child care	$15/visit for children through age 17
• Health maintenance visit	$15 each visit
• Immunization visit	
• Breast screening exam and mammogram	
• Pap smear and exam	
• Colorectal and prostate cancer screenings	

Hospital Inpatient Care	You Pay
Physician, surgeon and surgical Services	$750 per admit
Private duty nursing if determined to be medically necessary by a Plan Physician	
Room and board, and critical care units	
Anesthesia	
Drugs, blood, blood products and their administration	
Lab, x-ray, and other diagnostic Services	
Dressings, casts, and medical supplies	
Covered transplants	
Bariatric surgery	30% Coinsurance

Ambulance Services	You Pay
	20% of charges-up to $500 per trip

Chemical Dependency Services	You Pay
Inpatient medical detoxification	$750 per admit
Outpatient individual therapy	$30 each visit Up to 20 visits per contract year
Outpatient group therapy	50% of individual therapy Copayment or Coinsurance rounded down to the nearest dollar – year limit, if any, applies
Residential rehabilitation	50% up to 30 days per contract year See attached benefit description

Complementary and Alternative Medicine	You Pay
Chiropractic Services	$30 each visit/20 visit per contract year See attached benefit description
Acupuncture Services	No Benefit

Dialysis Care	You Pay
	$50 each visit

Drugs, Supplies and Supplements	You Pay
Administered Drugs	No Charge
Drugs described in the "Benefits" section under the heading "Outpatient Prescription Drugs"	$10 Generic/$30 brand per prescription up to 30-day supply See attached benefit description

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable medical equipment	See attached benefit description
Prosthetic and orthotic devices	See attached benefit description

Emergency Services and Non-Emergency, Non-Routine Care	You Pay
Plan and non-plan emergency rooms (covered 24 hours a day)	$100 each visit Waived if admitted as an inpatient
Non-emergency, non-routine visits received in Plan Facilities **after** regular office hours	$50 each visit

Family Planning Services	You Pay
Family planning counseling	$30 each visit
Associated outpatient surgery procedures	$150 each visit

Health Education Services	You Pay
Health education classes	Charges vary
Training in self care and preventive care, including group visits	Charges vary
Health education publications	No Charge

Hearing Services	You Pay
Hearing tests to determine the need for hearing correction	$30 each visit
Hearing aids	See attached benefit description

Home Health Care	You Pay
Health Services provided in your home and prescribed by a Plan Physician	No Charge
Special Services Program For hospice-eligible members who have not yet elected hospice care	No Charges 15 visits per lifetime

Hospice Care	You Pay
Home-based hospice care for terminally ill patients	No Charge

Infertility Services	You Pay
All covered Services related to the diagnosis and treatment of infertility	50% Copayment each visit See attached benefit description
Artificial insemination, including associated x-ray and laboratory Services	50% Copayment each visit See attached benefit description

Mental Health Services	You Pay
Outpatient individual therapy	$30 each visit Up to 20 visits per contract year
Outpatient group therapy	50% of individual therapy Copayment or Coinsurance rounded down to the nearest dollar –year limit, if any, applies
Visits for the purpose of monitoring drug therapy (year limit, if any, does ***not*** apply for these visits)	$30 each visit Up to 20 visits per contract year
Inpatient psychiatric hospitalization	$750 per admit Up to 45 days per contract year
Inpatient professional visits	No Charge

Oxygen	You Pay
	See attached benefit description

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient physical, occupational and speech therapy Services	No Charge
Short-term outpatient physical, occupational and speech therapy visits	$30 each visit up to two months or 20 visits per year pulmonary rehab $5 Copayment
Treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility	No charge for up to 60 days per medical episode

Reconstructive Surgery	You Pay
	$750 per admit excludes bariatric surgery

Skilled Nursing Facility Care	You Pay
	No Charge 100 days per contract year

Transplant Services	You Pay
	Hospital and Office Visit Copay apply

Vision Services	You Pay
Eye refraction exams	$30 each visit
Corrective eyeglass lenses, frames and cosmetic contact lenses	No Benefit

X-ray, Laboratory and Special Procedures	You Pay
Diagnostic laboratory and x-ray Services	No Charge
Therapeutic x-rays	$50 each visit
Special procedures such as CT, PET, MRI, nuclear medicine	$100 copay per procedure

Annual Out-of-Pocket Maximums

There are limits to the total amount of Copayments or Coinsurance you must pay in a year for certain Services covered under this EOC. Those limits are:

- $100/Member per contract year
- $3000/Family per contract year

The Copayments or Coinsurance paid by different family Members cannot be combined to have one Member certified as having met the Copayment annual limit applicable to each Member.

Copayments or Coinsurance for the following covered Services apply toward these limits:

- After hours urgent care
- Ambulance Services, only when medically necessary
- Chemical dependency treatment for diagnosis, medical treatment including medical detoxification and referral to a specialized facility, but **not** the services of the specialized facility
- Diagnostic lab and x-ray Services, and therapeutic x-ray Services provided in support of basic health services, including MRI, CT, PET and nuclear medicine
- Emergency Services
- Home health Services
- Hormonal treatment of prostate cancer
- Hospice care
- Infertility Services
- Inpatient hospital care (not including inpatient mental health care)
- Medical office visits, including primary care and specialty care visits
- Outpatient mental health visits (first 20 visits)
- Outpatient surgery
- Preventive Services
- Short-term physical, speech and occupational therapy, and multidisciplinary rehabilitation Services

Copayments or Coinsurance for a benefit or Service that is not covered under your particular health plan coverage will not apply toward the limit.

When you pay a Copayment or Coinsurance for these Services, it is important to ask for and keep the receipts. When the receipts add up to the annual Copayment limit, call the Patient Business Services Department at **303-743-5900**. A staff member will verify whether the limit has been met and if so, issue a “Waiver Card” in the family member’s name who has met the limit, along with a letter explaining how to use the card. This Waiver Card will show that you do not have to pay any more Copayments or Coinsurance for the specified Services for the remainder of the year.

Dependent Limiting Age Requirement

The Dependent limiting age as described under Dependents in the "Eligibility and Enrollment" section is the end of the month in which age 25 is reached. An unmarried Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements.

Dependent Student Limiting Age Requirement

The Dependent student limiting age as described under Dependents in the "Eligibility and Enrollment" section is the end of the month in which age 25 is reached. A full-time student in an accredited college or school, who is financially dependent on you or your spouse, will continue to be eligible until the Dependent student reaches this age, if he or she continues to meet all other eligibility requirements.

Colorado Springs

$10.00 GENERIC / $30.00 BRAND PRESCRIPTION DRUG BENEFIT

(NOTE: When used in this Evidence of Coverage, the term "preferred" refers to drugs that are included in the Health Plan Drug Formulary and the term "non-preferred" refers to drugs that are not included in the Health Plan Drug Formulary.)

Prescribed covered drugs (except for internally implanted time-release drugs and drugs for hormonal treatment of prostate cancer) are provided at a maximum charge of $10.00 for each preferred generic drug or $30.00 for each preferred brand-name drug or medication not having a generic or a generic equivalent.

Prescribed supplies and accessories, including, but not limited to, home glucose monitoring supplies, glucose test tablets and tape, acetone test tablets, nitrate urine test strips for pediatric patients, and disposable syringes, are provided upon payment of 20% of Medicare-approved charges for a 30-day supply per item, and when obtained at Plan Pharmacies or from sources designated by Health Plan.

Prescribed injectable drugs for hormonal treatment of prostate cancer are provided at a Copayment of 20% of Member charges.

The amount prescribed cannot exceed a 30-day supply for maintenance drugs or part of a 30-day supply for non-maintenance drugs. Each prescription refill will be provided subject to the same conditions as the original prescription.

Generic drugs that are available in the United States only from a single manufacturer and that are not listed as generic in the then-current commercially available drug database(s) to which Health Plan subscribes are provided at a maximum charge of $30.00 for a 30-day supply for maintenance drugs or part of a 30-day supply for non-maintenance drugs.

Refills of maintenance drugs may also be filled by calling our convenient mail order prescription service, **ScripPharmacy**, which is available 24 hours a day. Contact **ScripPharmacy** customer service representatives at **1-800-677-4323** for more information. Refills will be mailed by first class U.S. Mail with no charge for postage and handling. Maintenance drug refills may be obtained by mail order for up to a 60 or 90-day supply, at a charge of two prescription drug Copayments, if prescribed by a Plan Physician. Maintenance drugs are determined by Health Plan. Certain drugs that have a significant potential for waste and diversion will be provided for up to a 30-day supply, at the applicable prescription drug Copayment, and are available by mail order service through our specialty provider, **Bio Scrip**. Contact **Bio Scrip** at **1-877-316-8921**.

The following drugs are covered only when prescribed by (i) a Plan Physician, (ii) a physician to whom a Member has been referred by a Plan Physician, or (iii) a dentist (when prescribed for acute conditions), and obtained at Plan Pharmacies:

- Drugs for which a prescription is required by law. Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Physician. If a Member requests a brand-name drug when a generic equivalent drug is the preferred product, the Member must pay $30.00, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Physician and the requested brand-name drug. If the brand-name drug is prescribed due to medical necessity, the Member pays only the brand-name Copayment.
- Insulin
- Internally implanted time-release drugs are provided at a charge determined by multiplying the charge for a 30-day supply of the drug by the expected number of months that it will be effective. No refund is given if the drug is removed before the end of its expected life.

LIMITATIONS:

- Some drugs may require prior authorization.
- Plan Physicians may request compound medications through the medical exception process. Medical necessity requirements must be met.

- Plan Physicians may apply for formulary exceptions in cases where it is medically necessary.

EXCLUSIONS:

- Prescription drugs that are necessary for services excluded in the Group's Evidence of Coverage
- Drugs and injections related to the treatment of sexual dysfunction
- Drugs or injections for treatment of involuntary infertility
- Drugs to shorten the duration of the common cold
- Drugs to enhance athletic performance
- Drugs that are available over the counter and by prescription for the same strength
- Drugs used in the treatment of weight control
- Any prescription drug packaging other than the dispensing pharmacy's standard packaging
- Any prescriptions dispensed as replacement of spilled, lost, damaged or stolen prescriptions
- Unless an exception is approved by Health Plan, drugs not approved by the FDA and not in general use as of March 1 of the year immediately preceding the year in which the applicable Group Agreement became effective or was last renewed.

RX307 (01-06) - RX-E4

HEARING AID BENEFIT

A $500.00 credit per ear, toward the purchase of a hearing aid is provided every 36 months when prescribed by a Plan Physician or audiologist and obtained from a provider approved by Kaiser Permanente. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound.

The credit must be used at the initial point of sale.

EXCLUSIONS:

- Hearing aids recommended prior to the effective date of coverage or after termination of coverage
- Replacement parts for the repair of a hearing aid
- Replacement of lost or broken hearing aids
- Accessory parts and routine maintenance
- Batteries

HEAR0P1 (01-04) -- HEAR-P1

CHEMICAL DEPENDENCY RESIDENTIAL REHABILITATION BENEFIT

The determination of the need for services of a residential rehabilitation program under this benefit, and referral to such a facility or program, is made by or under the supervision of a Plan Physician.

During any contract year, up to 30 days of inpatient services in a residential rehabilitation program approved by Kaiser Permanente for treatment of alcoholism, drug abuse or drug addiction, are provided upon payment of 50% of charges.

Day/night (partial hospitalization) treatment may be used in place of the inpatient days, if approved by a Health Plan Provider (2 day/night sessions will be equal to 1 inpatient day).
CDRR055 (07-05) -- CDRR-CB

CHIROPRACTIC SERVICES

Coverage includes evaluation, laboratory services and x-rays required for chiropractic services, and treatment of musculoskeletal disorders by participating chiropractors for $30.00 each visit. Up to 20 self-referred visits per contract year are covered when services are provided by participating chiropractors.

EXCLUSIONS:

Any treatment or services delivered by a participating chiropractor or his or her employee, determined not to be chiropractically necessary by a participating chiropractor, or services in excess of the benefit maximum; Treatment or services for pre-employment physicals; hypnotherapy, behavior training, sleep therapy or weight loss programs; laboratory tests, x-rays or other treatment classified as experimental or in the research stage that have not been documented as chiropractically necessary or appropriate; services not related to the examination and/or treatment of the musculoskeletal system; vocational rehabilitation services; thermography; air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances; transportation costs including local ambulance charges; prescription drugs, vitamins, minerals, nutritional supplements or other similar-type products; educational programs; non-medical self-care, or self-help training; any or all diagnostic testing related to these excluded services; MRI and/or other types of diagnostic radiology; physical or massage therapy that is not a part of the chiropractic treatment.; and durable medical equipment and/or supplies for use in the home.
CHIR0C2 (07-05) - - CHIR-C2

DURABLE MEDICAL EQUIPMENT AND ORTHOTIC AND PROSTHETIC DEVICES

(100% Covered)
($2,000 Maximum Benefit Per Contract Year)

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, durable medical equipment, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided without charge for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge. After the maximum benefit per contract year is paid by Health Plan, additional items of durable medical equipment, prosthetics, orthotics and/or necessary repairs and adjustments are provided at Non-Member Rates.
Health Plan follows Medicare guidelines to determine which DME items will be provided to Members.
Limitations. Coverage is limited to:

- a standard item of durable medical equipment, orthotic device or prosthetic device that adequately meets a Member's medical needs.

- an annual maximum benefit of $2,000 paid by Health Plan per contract year.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment is equipment that is appropriate for use in the home, able to withstand repeated use, medically necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment. (Please see the oxygen benefit description for more details regarding oxygen coverage.)
Insulin pumps and insulin pump supplies are provided for Type I diabetes when clinical guidelines are met and when obtained from sources designated by Health Plan. The maximum benefit does not apply to insulin pumps.
When use is no longer prescribed by a Plan Physician, durable medical equipment must be returned to Health Plan or its designee. If the equipment is not returned, the Member must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

DME Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

DME Exclusions:

- Electronic monitors of bodily functions, except infant apnea monitors are covered
- Devices to perform medical testing of body fluids, excretions or substances, except that nitrate urine test strips for home use for pediatric patients is covered
- Non-medical devices such as whirlpools, saunas and elevators
- Exercise or hygiene equipment
- Comfort, convenience or luxury equipment or features
- Disposable supplies for home use such as bandages, gauze, tape, antiseptics and ace-type bandages
- Replacement of lost equipment
- Repair, adjustments or replacements necessitated by misuse
- More than one piece of durable medical equipment serving essentially the same function, except for covered replacements; spare equipment or alternate use equipment not provided

PROSTHETIC DEVICES

Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity.

Coverage of prosthetic devices includes:

- Internally implanted devices for functional purposes, such as pacemakers and hip joints. The maximum benefit does not apply to internally implanted devices.
- Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary. The maximum benefit does not apply to prosthetic devices needed following a mastectomy.
- Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate in newborn Members are covered, when prescribed by a Plan Physician and obtained from sources designated by Health Plan. The maximum benefit does not apply to prosthetic devices needed for the treatment of cleft lip and cleft palate.
- Prosthetic devices intended to replace, in whole or in part, an arm or leg, are provided when prescribed by a Plan Physician as medically necessary and when obtained from sources designated by Health Plan. Payment by Health Plan will be in accord with Medicare guidelines. The maximum benefit does not apply to prosthetic arms and legs.

Prosthetic Device Exclusions:

- Dental prostheses, except for medically necessary prosthodontic treatment for treatment of cleft lip and cleft palate in newborn Members, as described above
- Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction
- More than one prosthetic device for the same part of the body, except for replacements; spare devices or alternate use devices not provided
- Replacement of lost prosthetic devices
- Repairs, adjustments or replacements necessitated by misuse

ORTHOTIC DEVICES

Orthotic devices are those rigid or semi-rigid external devices (other than casts) that are required to support or correct a defective form or function of an inoperative or malfunctioning body part, or to restrict motion in a diseased or injured part of the body.

Orthotic Device Exclusions:

- Corrective shoes and orthotic devices for podiatric use and arch supports
- Dental devices and appliances except that medically necessary treatment of cleft lip or cleft palate for newborn Members is covered when prescribed by a Plan Physician, unless the Member is covered for these services under a dental insurance policy or contract
- Experimental and research braces
- More than one orthotic device for the same part of the body, except for covered replacements; spare devices or alternate use devices
- Replacement of lost orthotic devices
- Repairs, adjustments or replacements necessitated by misuse

DMES0D0 (01-06) -- DMES-D0

INFERTILITY BENEFIT

Members must pay a charge of 50% of Member charges for medical services received for diagnosis and treatment of infertility, including x-ray and laboratory procedures in conjunction with infertility treatment.

Artificial insemination (intrauterine insemination) is provided for all medically appropriate candidates, upon payment of 50% of Member charges. X-ray and laboratory services in conjunction with conception by artificial means are provided upon payment of 50% of Member charges.

EXCLUSIONS:

- Donor semen, donor eggs and services related to their procurement and storage
- All other services related to conception by artificial means including prescription drugs related to such services. Such non-covered services include but are no limited to: invitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer.
- Services to reverse voluntary, surgically induced infertility

INFT-5X (01-05) – INFT-5X, INFT-H5

OXYGEN AND OXYGEN EQUIPMENT

(Oxygen - 20% Charge)

Oxygen and oxygen dispensing equipment used in the Member's home (including an institution used as his or her home) is covered in the Service Area upon payment of 20% of Member charges.

Oxygen refills are covered when a Member is temporarily traveling outside the Service Area, if the Member has an existing oxygen order and obtains refills from Health Plan's designated oxygen vendor.

OXYG0M8 (01-04) -- OXYG-M8, OXYG-2X, OXYG-80